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Medicaid Managed LTSS for ADRD: Evidence from Wisconsin

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Motivation

- **Medicaid is a key pillar of the US social safety net, esp. for those with LTSS needs**
  - Largest funder of long-term supports and services (approx. 33% of budget but 6% of enrollees)
  - Concerns about access: e.g., waitlists for home- and community-based services
- **States increasingly shifting to managed care models: 10% in 1990, 80% today**
  - Premise: cost control, improve coordination, better access to preferred care settings
  - Concerns: reduction in key services
- **Much of early managed care growth focused on non-elderly, non-disabled pop**
- **More recently, 22 states have managed care programs for LTSS**
- **Little evidence on its effects on LTSS population, esp. for individuals with ADRD**

This project

Research questions:

1. **Who selects into managed Medicaid LTSS?**
   - By care needs, demographics, preferences

2. **What is the effect of managed Medicaid LTSS on service use for older adults?**
   - By ADRD status

Data and methods:

- Administrative Medicaid (+LTSS) claims + functional assessment data from WI
  - Care preferences, living situation, etc.

- Staggered county roll-out of voluntary managed LTSS in WI from 2000-2018

Outline for today

1. Related literature
2. Our context: Family Care in Wisconsin
3. Policy variation
4. Medicaid data (not in hand yet – hopefully close)
5. Empirical framework
6. Preliminary results using LTC Focus data

Related literature

- **Effects of Medicaid managed care for other populations**
  - Duggan et al. (2021) and Layton et al. (2022) [adults with disabilities], Kuziemko et al. (2018) [infants], Currie and Fahr (2005) [children]
  - Duggan et al. (2021) find increase in mortality and ED visits, esp. among sicker patients
  - **Our paper: evidence of the effects of managed care for a particularly high-need population**

- **Voluntary vs mandatory managed care**
  - Geruso and Layton (2020), Brown et al. (2014)
  - Geruso and Layton (2020) find individuals who select into Medicare managed care are healthier
  - **Our paper: evidence of the effects of voluntary MLTSS**

- **Effects of institutionalized care vs HCBS more broadly**
  - Correlation between HCBS and hospitalization rates, spending (Konetzka et al., 2012; Gorges et al., 2019; Grabowski, 2006); harder to find causal evidence

What is Medicaid (LTSS) managed care?

- **Medicaid LTSS**
  - Covers services and supports people may need when they have a chronic illness, disability, or aging-related condition that limits their ability to do daily tasks
  - Eligibility typically based on (1) income / asset test, (2) functional screen
  - Functional screen assesses physical/intellectual/developmental disabilities, cognitive issues, mental health

- **Traditionally, Medicaid pays providers on a fee-for-service basis for an enrollees care**
  - Largely covers nursing home care but also some HCBS (through waivers)

- **Alternative to fee-for-service Medicaid: managed care**
  - Medicaid pays managed care organizations a fixed amount to absorb the financial risk of covering enrollee
  - Managed care plans tend to emphasize care coordination, prioritize HCBS over institutional care
  - Concern they have incentives to skimp on services (→ negative quality and health impacts)
  - E.g., individuals with ADRD are predictably higher-cost enrollees, so plans have an incentive to skimp on the provision of LTSS in these populations to discourage their enrollment

Our context: Wisconsin's Family Care program

- **Wisconsin Medicaid's "Family Care" program provides unique setting:**
  - Voluntary managed care program
  - Gradually rolled out across all counties between 2000 and 2018
  - Entitlement program: can enroll if meet income/asset limits and pass functional screen

- **Services provided:**
  - All traditional HCBS: adult day care, home care, transportation, bathing services, financial management and medication management, home modifications, etc.
  - Medicaid card services related to LTSS: personal care, home health, physical/occupation/speech therapy, durable medical equipment, mental health services, skilled nursing care
  - Case management by social worker / nurse team
  - No acute / primary care services, but medical coordination

A bit of history

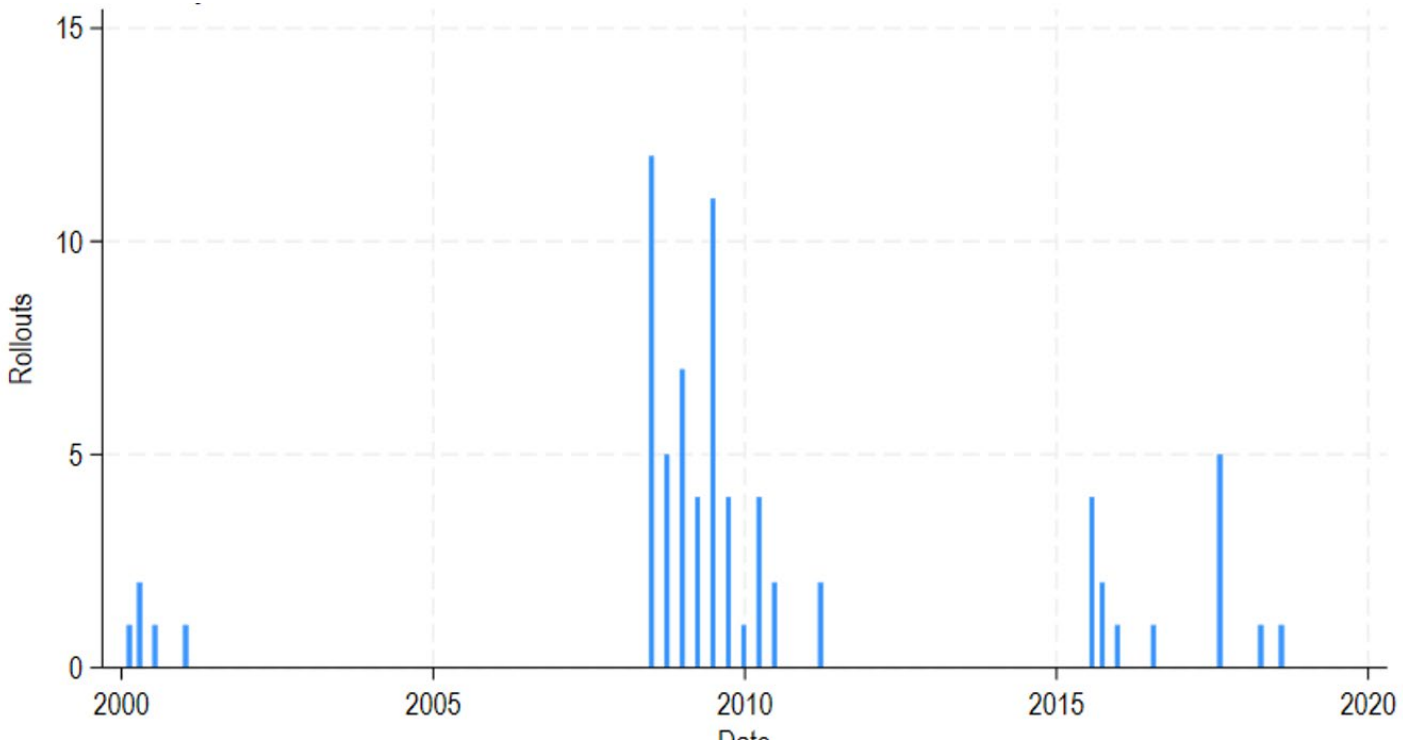
- **1980s: 1st generation of Medicaid reforms for long-term care in WI**
  - First used state Medicaid $ to fund HCBS, then additionally applied for federal HCBS waivers
  - But this was a fixed amount of funding, and resulted in waiting lists for HCBS

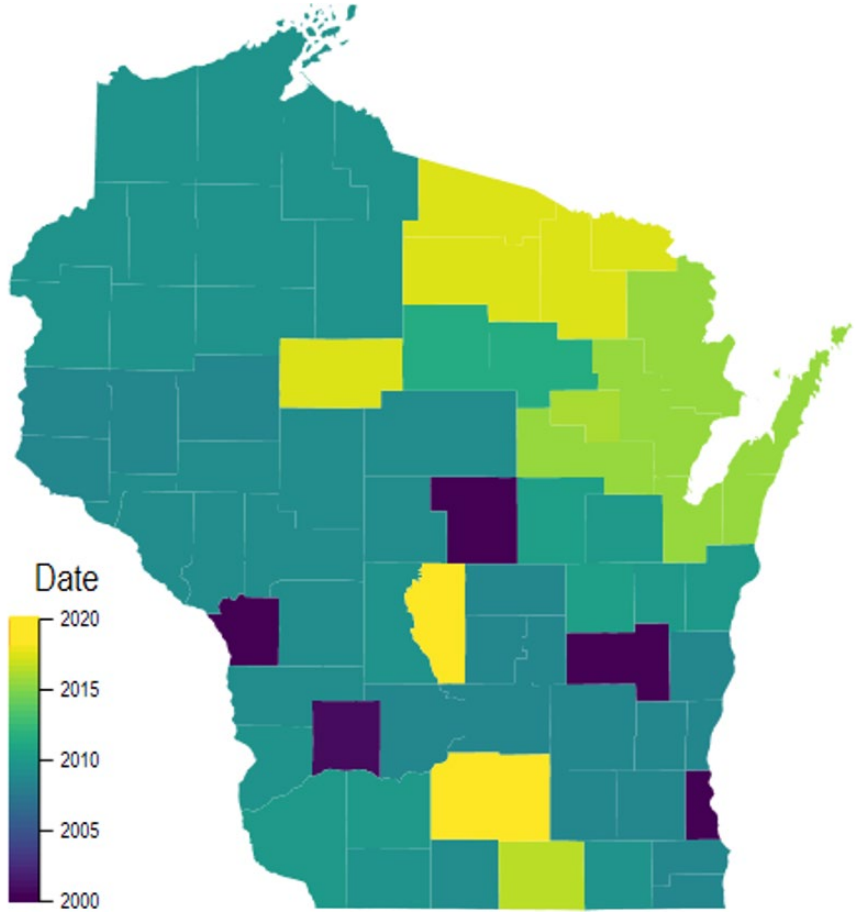
- **Late 1990s: 2nd generation of Medicaid reforms for long-term care in WI**
  - Goal was a system with equal access to nursing homes and HCBS
  - Resulted in 5-county pilot of “Family Care”

- **Early program evaluations in the pilot counties pointed to success**
  - Expanded choice and access, Medicaid cost savings of $452 per month
  - In response to these encouraging results, Family Care expanded to an additional 51 counties by 2010, and statewide (to all 72 counties) by 2018 after legislative action in 2015.

Family Care policy variation

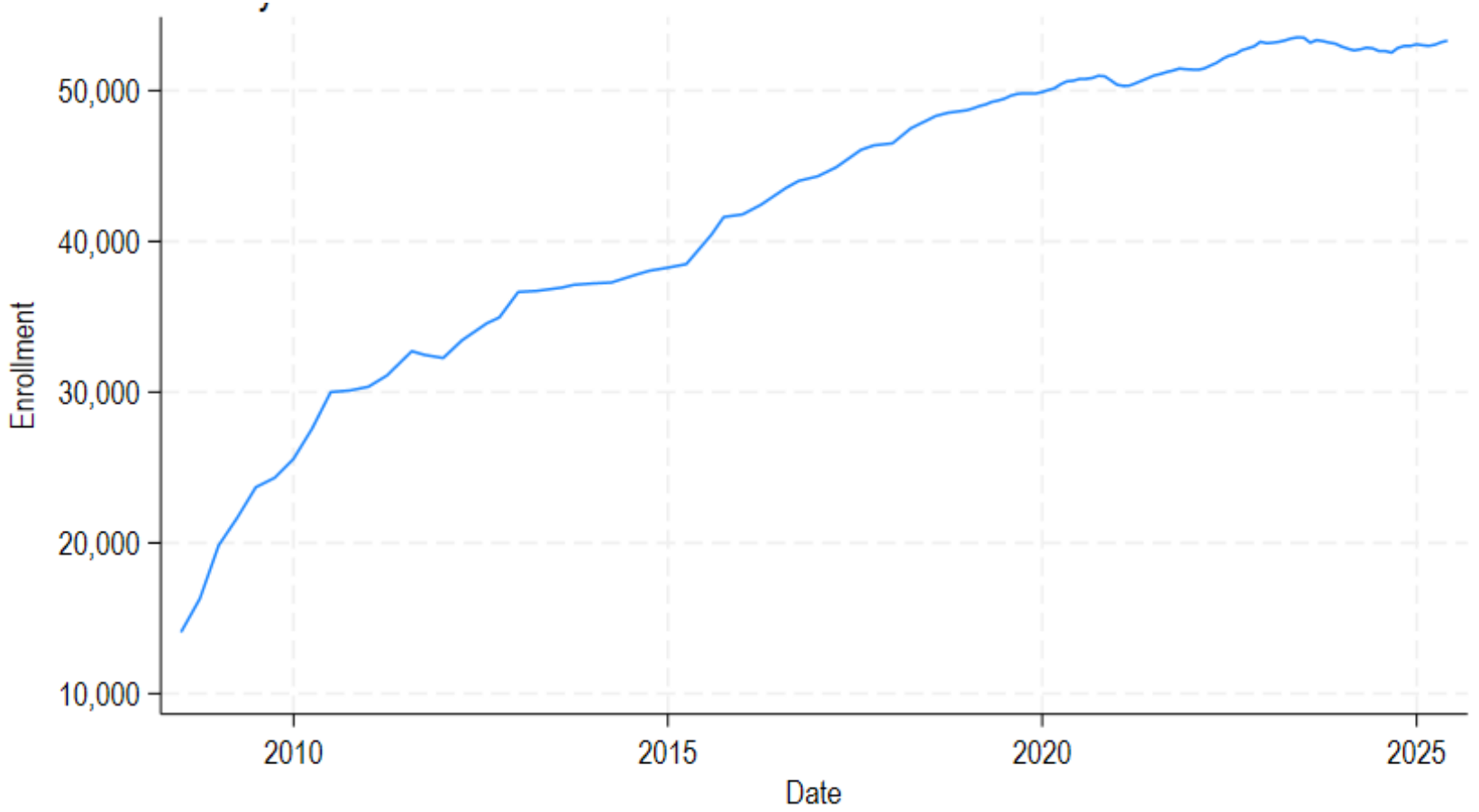
Date of Family Care entry by county





Family Care policy variation

Cumulative Family Care enrollment over time



Wisconsin Medicaid data

- **Medicaid enrollment and claims files**
  - Contains detailed program eligibility, managed care enrollment, demographics, and Medicaid-paid health care utilization (including outpatient, inpatient, pharmacy claims)
  - Medicaid-paid LTSS utilization (newly available)
- **Long-Term Care Functional Screen**
  - Clinical and functional needs
  - Demographic and family information
  - Preferences over LTC setting

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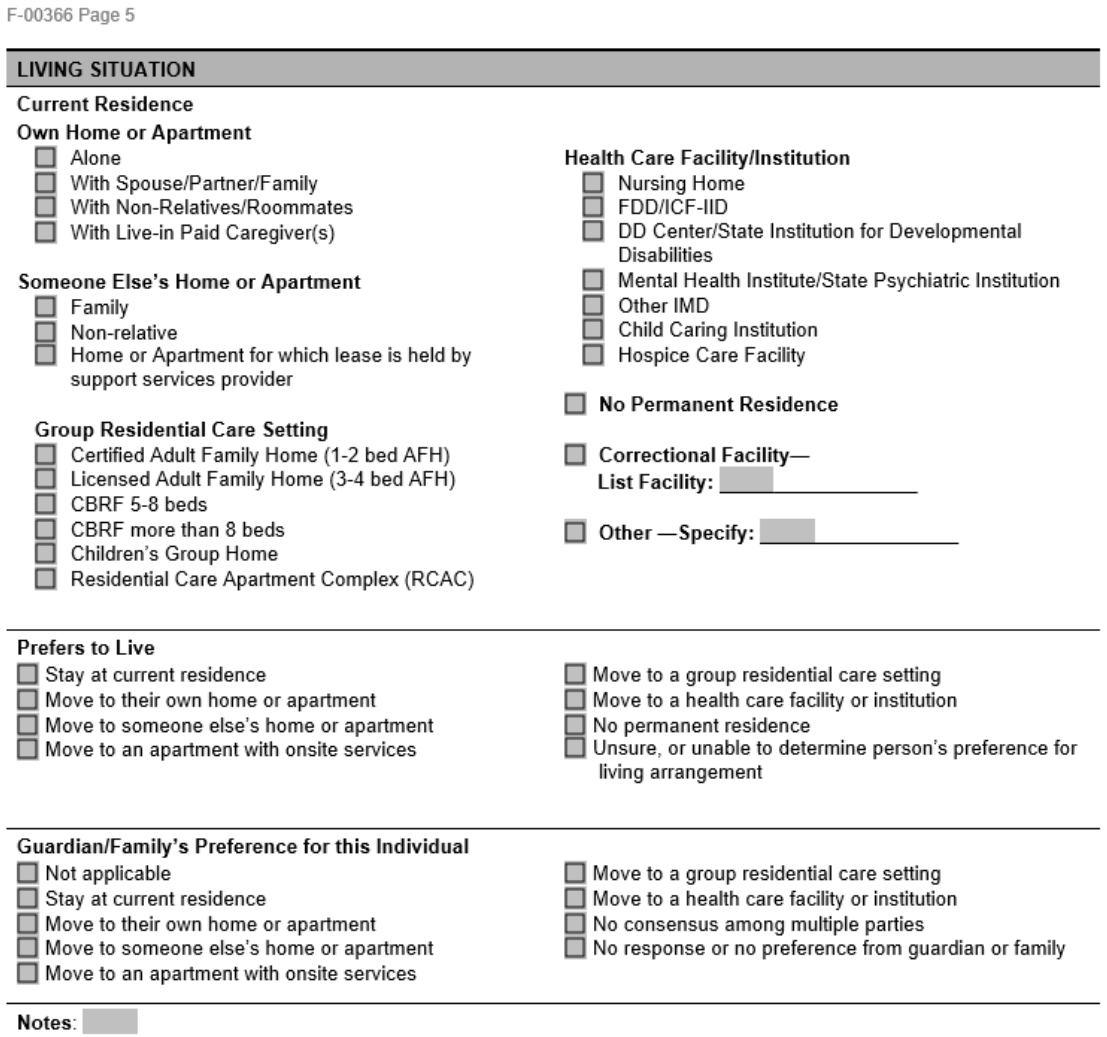
Page 5 of Long-Term Care Functional Screen



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LIVING SITUATION

Current Residence

Own Home or Apartment
- ☐ Alone
- ☐ With Spouse/Partner/Family
- ☐ With Non-Relatives/Roommates
- ☐ With Live-in Paid Caregiver(s)

Someone Else's Home or Apartment
- ☐ Family
- ☐ Non-relative
- ☐ Home or Apartment for which lease is held by support services provider

Group Residential Care Setting
- ☐ Certified Adult Family Home (1-2 bed AFH)
- ☐ Licensed Adult Family Home (3-4 bed AFH)
- ☐ CBRF 5-8 beds
- ☐ CBRF more than 8 beds
- ☐ Children's Group Home
- ☐ Residential Care Apartment Complex (RCAC)

Health Care Facility/Institution
- ☐ Nursing Home
- ☐ FDD/ICF-IID
- ☐ DD Center/State Institution for Developmental Disabilities
- ☐ Mental Health Institute/State Psychiatric Institution
- ☐ Other IMD
- ☐ Child Caring Institution
- ☐ Hospice Care Facility

- ☐ **No Permanent Residence**
- ☐ **Correctional Facility— List Facility:** _____
- ☐ **Other —Specify:** _____

Prefers to Live
- ☐ Stay at current residence
- ☐ Move to their own home or apartment
- ☐ Move to someone else's home or apartment
- ☐ Move to an apartment with onsite services
- ☐ Move to a group residential care setting
- ☐ Move to a health care facility or institution
- ☐ No permanent residence
- ☐ Unsure, or unable to determine person's preference for living arrangement

Guardian/Family's Preference for this Individual
- ☐ Not applicable
- ☐ Stay at current residence
- ☐ Move to their own home or apartment
- ☐ Move to someone else's home or apartment
- ☐ Move to an apartment with onsite services
- ☐ Move to a group residential care setting
- ☐ Move to a health care facility or institution
- ☐ No consensus among multiple parties
- ☐ No response or no preference from guardian or family

Notes:

Characterizing ADRD in Medicaid data

- Most studies using Medicare claims data use the CCW or Bynum algorithm to flag individuals with ADRD (basically a set of ICD codes)
- Unclear if those ICD codes captured in Medicaid data for frail elderly
- We would be grateful for any leads on this / related studies!
  - Validation exercises, alternative algorithms, etc.

Empirical framework for research question #2

What is the effect of managed Medicaid LTSS on service use for older adults?

For causal identification, we exploit the staggered roll-out of Family Care across counties

Event study specification (also do Callaway & Sant'anna 2021):

$$Y_{ct} = \sum_{\tau=-9,\tau\neq-1} \beta_\tau 1\{t - FC_c = \tau\} + \alpha_c + \lambda_t + \varepsilon_{ct}$$

for outcome Y_{ct} in county c in quarter t, where τ is time since Family Care roll-out date (FC_c)

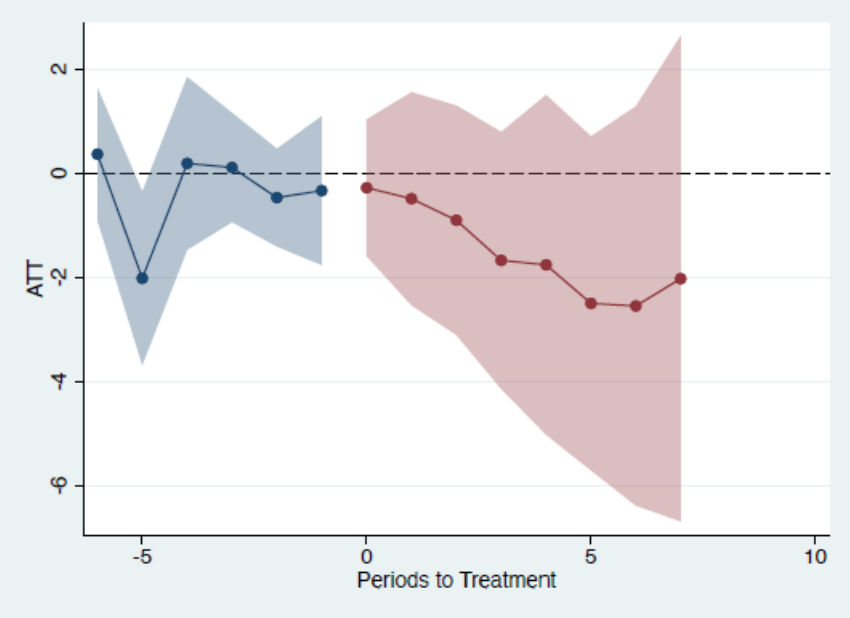
Preliminary results using LTC Focus data

- **Plan to use Medicaid claims to estimate effects on LTSS outcomes:**
  - probability of nursing home entry
  - expenditures on home- and community-based services

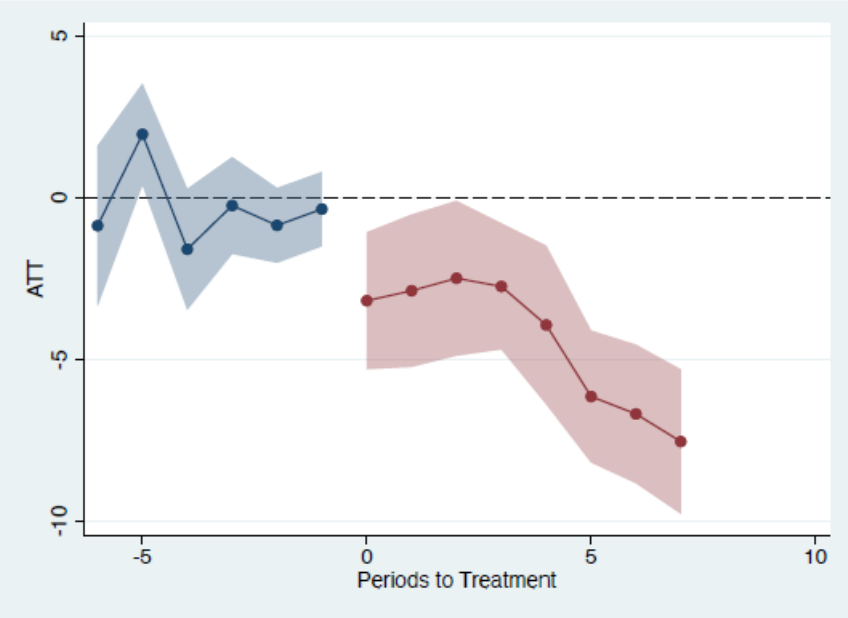
- **We will examine heterogeneity by ADRD status, LTSS needs**

- **For now, we use LTC Focus data linked to our policy variation:**
  - Facility & resident characteristics, admissions for every CMS-certified nursing home 2000-2017
  - Construct outcomes at the county-year level:
    - Nursing home residents per 1000 persons aged 70+
    - Share of residents with Medicaid as primary payer

Preliminary results using LTC Focus data



(a) NH residents per 1,000
Mean: 50.7; ATE (SE): -1.38 (1.40)



(b) Share of NH residents using Medicaid
Mean: 64.2; ATE (SE) -4.46 (0.87)

- Family Care led to a decrease in nursing home residency and in the share of residents on Medicaid
- Consistent w/ Family Care goal of shifting patients out of institutionalized care and into community

Summary of Current Progress

Preliminary Steps

- IRB approval obtained
- Project approval requested from DHS, at top of the priority list

Empirical design

- Empirical plan finalized and coded
- ADRD measurement in progress

Data cleaning

- Medicaid enrollment and claims available and cleaned; analysis can begin pending project approval
- LTSS data delivery pending project approval

Analysis

- Preliminary analysis using alternative data (LTC Focus) complete
- Draft sketched out

Conclusion and next steps

- Coverage of LTSS for low-income indiv. has evolved dramatically over past two decades
  - Towards managed care models
  - Towards home-based care
- Concerns over whether such payment models will skimp on care for the most vulnerable
  - Like those with ADRD
- This project studies the effects of the gradual roll-out of Medicaid managed care for LTSS across counties in Wisconsin over the past 20 years
  - Preliminary findings suggest a shift away from institutionalized care

- Next step is to supplement with Medicaid claims data to document:
  - Characteristics of individuals who opt into managed care
  - Service utilization, particularly for vulnerable groups like those with ADRD

Thank you!

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